CHILD HISTORY FACT SHEET

PATIENT NAME: _____
MR#: _____ DOB: _____
Religion: _____ Nationality: _____
Marital status of parent(s): married separated divorced remarried widowed single
Child resides with: parent(s) mother father guardian foster parent other _____

DNR STATUS: _____
(DNR order should be clearly placed in chart)

People whom the child presently resides with:
Name: Age: Relationship:
_____
_____
_____
_____
_____

TRANSPORTATION: _____
Handicap sticker: _____
Transport Company: _____
Phone: _____ Fax: _____
Special considerations: _____

HOUSING: _____
_____
_____
_____

INSURANCE
•Primary Ins: _____
ID#: _____
Subscriber: _____
Phone #: _____
Case Mgr: _____
•Secondary Ins: _____
ID#: _____
Subscriber: _____
Phone #: _____
Case Mgr: _____
•Medicaid: (type) _____
ID#: _____
Phone #: _____
Case Mgr: _____
•BCMH: _____
ID#: _____
Phone #: _____
Case Mgr: _____
•SSI: _____
_____
•Other: _____
_____
_____

HOME CARE AGENCY
Name: _____
Phone: _____ Fax: _____
Hours/Shifts: _____
Services Provided: _____
Supervisor: _____
Name: _____
Phone: _____ Fax: _____
Hours/Shifts: _____
Services Provided: _____
Supervisor: _____

SPECIAL INFO ABOUT ME: _____
_____
_____

CAREGIVERS:
Caregiver _____ relationship to child _____
DOB: ___/___/___ SS# _____
Address: _____
_____
Phone(H): _____ Phone(W): _____
Education: _____ Literacy: _____
Disabilities: _____
Employment: _____ Hours: _____
_____
_____

Caregiver _____ relationship to child _____
DOB: ___/___/___ SS# _____
Address: _____
_____
Phone(H): _____ Phone(W): _____
Education: _____ Literacy: _____
Disabilities: _____
Employment: _____ Hours: _____
_____
_____

Other Caregivers/Contact persons: _____
_____
_____
_____

PROGRAMS
•Early Intervention Services: _____
_____
Case Mgr: _____ Phone: _____
•MRDD Services: _____
_____
Case Mgr: _____ Phone: _____
•Family Resources: _____
•WIC: Office: _____
Phone: _____ Fax: _____
•Hospice Provider: _____
Contact: _____
Phone: _____ Fax: _____
•School: _____
Phone: _____ Fax: _____
_____
•Other: _____
_____
_____
_____
_____
_____
_____
_____

SPECIALISTS:

•MD: _____ Division: _____
Phone: _____ Fax: _____
Contact: _____
•MD: _____ Division: _____
Phone: _____ Fax: _____
Contact: _____
•MD: _____ Division: _____
Phone: _____ Fax: _____
Contact: _____

DME

Name: _____ Contact: _____
Phone: _____ Fax: _____
Supplies provided: _____
_____
Name: _____ Contact: _____
Phone: _____ Fax: _____
Supplies provided: _____
_____
Name: _____ Contact: _____
Phone: _____ Fax: _____
Supplies provided: _____
_____

THERAPIES

OT Provider: _____ Contact: _____
Phone: _____ Fax: _____
Frequency: _____
PT Provider: _____ Contact: _____
Phone: _____ Fax: _____
Frequency: _____
ST Provider: _____ Contact: _____
Phone: _____ Fax: _____
Frequency: _____
Therapies at school: _____
_____

•MD: _____ Division: _____
Phone: _____ Fax: _____
Contact: _____
•MD: _____ Division: _____
Phone: _____ Fax: _____
Contact: _____
•MD: _____ Division: _____
Phone: _____ Fax: _____
Contact: _____
•MD: _____ Division: _____
Phone: _____ Fax: _____
Contact: _____
•MD: _____ Division: _____
Phone: _____ Fax: _____
Contact: _____

•MD: _____ Division: _____
Phone: _____ Fax: _____
Contact: _____
•MD: _____ Division: _____
Phone: _____ Fax: _____
Contact: _____
_____
_____
_____
_____
_____

SPECIAL LETTERS TO FAMILIES:

•Electric Co: _____
•Water/Sewage: _____
•Fire Department: _____
•Telephone Co: _____

SUPPORT AND RESOURCES FAMILY RELIES ON:

_____
_____
_____
_____
_____
_____